

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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MEDICAID BULLETIN

ALL-GENERAL 07-07

TO: Medicaid Providers and Transportation Brokers

SUBJECT: Program Guidelines and Policy Clarification

- I. Non-Covered Transportation**
- II. Non- Emergency Ambulance Services Outside of the Transportation Broker**
- III. The Non- Emergency Transportation Broker Program**

The Department of Health and Human Services (DHHS) is providing additional guidance and clarification of Medicaid policy for Non-Emergency Medicaid Transportation Services (NEMT). NEMT services may only be used to transport eligible beneficiaries to Medicaid covered services. DHHS will ensure the quality of beneficiary transportation. Medicaid beneficiaries requiring non-emergency transportation are entitled to reliable and safe service. The majority of NEMT services are provided through the Transportation Broker program. Transportation Brokers are required to measure and report the quality of service furnished by their provider networks. DHHS expects the Broker's service providers to adhere to timely pick-up and departure schedules. Additionally, properly authorized non-emergency ambulance transports, which are reimbursed as Medicaid fee-for-service, are available only for medically unstable individuals whose condition necessitates active medical care or intervention by an emergency medical technician (EMT) during the transport. This service is separate from the Transportation Broker program and requires authorization through DHHS Form 216.

I. Non-Covered Transportation:

NEMT may not be utilized to transport individuals not eligible for Medicaid or to transport eligible individuals to services that are not covered by Medicaid. Specific examples of non-covered transportation include transportation:

- Of any individual who is not Medicaid eligible at the time of the request for transport to and from a non-emergency medical appointment or service.
- Of any individual for the purposes of an eligibility determination or redetermination appointment.
- To medical services provided at Veterans Administration (VA) facilities, as they do not qualify as Medicaid covered services.
- Of any individual to the Department of Health and Environmental Control (DHEC); Women, Infants and Children (WIC) appointments.
- To facilities for vocational rehabilitation or to any related service.

II. Non-Emergency Ambulance Services Outside of the Transportation Broker:

Revised DHHS Form 216

Effective for dates of service on and after December 1, 2007, all providers submitting claims to DHHS for fee-for-service reimbursement are required to use the revised DHHS Form 216 (see attached form). DHHS Form 216 and policies have been modified as follows:

- A legible copy of the DHHS Form 216 must be submitted along with the electronic or paper claim for payment.
- In addition to the signature of the medical personnel authorized to request an Ambulance transport via DHHS Form 216, the name and title of the requestor must be legibly printed below the signature line.
- Requires the actual odometer reading of the transport vehicle when it is submitted for payment.

Ambulance Authorization Portion of Form 216

If a beneficiary's unstable medical condition requires active medical care or intervention by Emergency Medical Technicians (EMT) during the transport, the facility must authorize the transportation through the use of DHHS Form 216.

Medical Necessity Portion of Form 216

Ambulance transports via DHHS Form 216 are reserved only for those whose current medical condition are unstable and requires active, ongoing medical care throughout the transport (i.e. ongoing suctioning of tracheotomy; IV fluids; cardiac monitoring; assistance with administering oxygen). Inappropriate ambulance transports will not be reimbursed fee-for-service. DHHS will utilize appropriate medical personnel to review claims submitted for reimbursement with DHHS Form 216. By signing DHHS Form 216, the health care provider attests that all medical necessity criteria for non-emergency ambulance transport have been met.

DHEC Run Report

Effective for dates of service on and after December 1, 2007, DHHS will enforce ambulance program policy to require the DHEC "Run Report" be attached and submitted with each claim to support each transport billed. Providers who are filing claims electronically must insure that the DHEC Run Report is submitted to DHHS for claims submitted after the effective date. Claims submitted after the effective date without a DHEC Run Report will be rejected.

Guidelines for Ambulance Return Trip

Effective for dates of service on and after December 1, 2007, DHHS will enforce the policy for unlisted ambulance service to require that all return trips to the beneficiary's original place of pick-up must be billed using the unlisted ambulance service procedure code, A0999. See the procedure codes and modifiers listed below.

<u>Procedure Code</u> (Descriptor)	<u>Modifier</u>	<u>Destination</u>
A0428 (BLS, Non-Emergency Transport)	RP	Residence to Physician
A0425 (BLS, Mileage)	RP	Mileage (combine to and from)
A0999 (BLS, Return Trip)	PR	Physician to Residence

Two trips on the same day of service

<u>Procedure Code</u>	<u>Modifier</u>	<u>Destination</u>
A0428 (BLS, Non-Emergency Transport)	RP	1 st trip - Residence to Physician
A0425 (BLS, Mileage)	RP	1 st trip - Mileage (combine to/from)
A0999 (BLS, Return Trip)	PR	1 st trip - Physician to Residence
A0428 (BLS, Non-Emergency Transport)	076 (Repeat)	2 nd trip - Residence to Physician
A0425 (BLS, Mileage)	076 (Repeat)	2 nd trip - Mileage (combine to/from)
A0999 (BLS, Return Trip)	076 (Repeat)	2 nd trip - Same date of service

NOTE: A trip is considered to be a pick up and a return to the original place of pick up.

III. The Non-Emergency Transportation Broker Program:

Routine Transports

Any scheduled transportation for Medicaid beneficiaries must be pre-arranged via direct contact with the regional Brokers. Facility staff must communicate a beneficiary's medical condition and specific transportation requirements to the Brokers. These transports require three days notification.

Wheelchair and Similar Mobility Aide Services

As indicated in the March 28, 2007, bulletin, effective May 1, 2007, Transportation Brokers shall provide non-emergency transportation for all Medicaid beneficiaries who utilize a wheelchair or similar ADA compliant mobility aid. This transportation benefit shall apply regardless of facility or location of the beneficiary within a region. These transports require three days notification.

Urgent Transportation

The Brokers are required to maintain a network of providers who shall furnish an appropriate mode of transportation for Medicaid beneficiaries to meet urgent transportation needs. Requestors for urgent transportation service and/or medical staff must communicate a beneficiary's medical condition and transportation requirements directly to the Broker. Urgent transportation includes, but is not limited to:

- Hospital or facility discharge.
- Urgent transportation for initial or follow-up medical service when directed by a medical professional.

To maximize access and minimize service delays, Transportation Brokers must:

- Dispatch an appropriate mode of transportation within three hours of the request for urgent transportation.

- Ensure adequate vehicle resources are available for urgent transportation.
- Ensure Call Center procedures that offer after hours access and ensure proper routing and timely access to transportation services.

Guidelines for Transportation to Adult Dental Services

Transportation To Covered Medicaid Dental Services

The Medicaid program has a limited adult dental program for those over 21 years of age. However, there are some dental procedures that qualify for transportation to the appointment. Beneficiaries over 21 years old are only eligible for transportation to the emergency dental services described below:

1. Extractions for the relief of:
 - Severe and acute pain
 - An infectious process in the mouth
2. Extractions and necessary treatment for repair of traumatic injury.
3. Full mouth extractions as necessary for catastrophic illnesses such as an organ transplant, chemotherapy, severe heart disease or other life threatening illnesses. Full mouth extractions require prior approval from the Dental Program area.

Full or partial dentures to replace extracted teeth, denture adjustments and denture reline are not Medicaid covered services for beneficiaries over 21, and therefore, NEMT may not be utilized to transport beneficiaries for those procedures.

NOTE: Transportation to dental services for Medicaid beneficiaries over age 21 who are enrolled in the Mentally Retarded/Related Disabilities (MR/RD) Waiver are exempt from the restricted dental services listed above. MR/RD Waiver participants are entitled to the same comprehensive dental services as beneficiaries under age 21 and are eligible for full transportation benefit without regard to beneficiary age.

Scheduling Transportation to Dental Appointments:

Any beneficiary that has severe or acute pain or an infection in the mouth would be considered an urgent, same day or next day trip for evaluation and treatment. The three-day notice for scheduling does not apply in these situations.

While services may be described as an “emergency dental service,” there may be more than one trip to the dentist required to resolve the beneficiary’s dental problem. During the evaluation, the dentist may determine that he must schedule a second appointment for an extraction for any of the following reasons:

- Health condition and/or medications
- Extent of infection
- Treatment may require more time for a more involved dental procedure

All subsequent appointments for extractions and follow up are considered related to the original dental emergency and transportation is available to the beneficiary.

Transportation to a dental appointment for evaluation and treatment of the dental emergency cannot be denied because the treatment has not been determined to be an extraction of the tooth or teeth involved. Treatment can only be determined after an assessment by the dental provider. Any subsequent appointments for restorative procedures (i.e. fillings, crowns), do not qualify for transportation.

Your continued support of the South Carolina Medicaid Program is appreciated. Please contact your Medicaid Program Manager at (803) 898-2655, if you have questions about the information contained in this bulletin.

/s/

Emma Forkner
Director

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Attachment

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